STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. Building B. Wing	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility failed to consult the resident's physician, when the resident had an injury and had the potential for requiring physical intervention and when there was a significant change in the resident's physical, mental or psychosocial status for one (Resident #1) of five residents reviewed for resident rights. The facility failed to consult Residents #1's physician when he was discovered to have a sudden and significant skin injury of large multiple blistering and skin coming off over the entirety of his left hand. The facility applied a dry dressing to the injury. Twenty-four hours later, the dressing was noted to be weeping and the blistering had tripled in size and the physician was notified. While waiting for transport to the ER, Resident #1 became unresponsive. At the ER, he was diagnosed with a 2nd degree thermal burn, sepsis and a UTI. This failure could place residents at risk of not having their physician consulted of changes in condition timely, resulting in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received the IJ template on 08/16/22 at 2:21 PM. Findings included: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (a broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision-making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period. Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of skin breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting resident dressed this morning, aide notified nurse of skin issues. On top of resident's left hand was cluster of blisters, with the biggest one observed to have opened up on the top of his left hand. Other smaller blisters observed over left finger areas. Hand cleaned and covered with dry dressing and wound care notified. Called and left voicemail for RP. There were no vitals noted for that observation. Review of Resident #1's July 2022 physician's orders did not reflect an order for treatment to his left hand. Review of Resident #1's nursing notes the next day on 07/25/22 at 7:31 AM written by LVN A reflected, While doing rounds at the end of shift, this nurse went to check on resident, dressing to left hand appeared slightly wet so nurse unwrapped it to assess before re-wrapping it. When dressing was taken off, this nurse noted existing rosy, red area to top of hand where the first blister had burst open the morning before. No drainage however noted to this area. To surrounding area was however noted multiple huge new clear fluid filled blisters around existing area, on all left fingers and knuckles, and two large blisters on the left palm of his hand. When nurse asked resident if he was in pain, he said no .MD notified immediately and order given to transfer to ER for further eval and to rule out any possible infections/contagious issues .While gathering resident's paperwork while resident was seated at the nurses' station, resident noted to become verbally unresponsive despite being given the sternal rub and was being shaken many times. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75. An interview with the hospital critical care RN on 07/28/22 at 12:37 PM revealed Resident #1 was presently at the hospital and had been diagnosed with second degree burns to his left hand, sepsis (the body's extreme response to an infection) and a UTI. The RN said when she first saw Resident #1's left hand, she was re-wrapping it to do wound care. He had blistering and a large open to the back of his left hand and blistering to the front and back down to where the wrist started. His skin on the left hand was blistered with a giant open area to the back of the hand that was red and granulated (having a roughened surface), blistering to all four digits and thumb on the outside and palm side of the hand. She said there were no more skin issues beyond the left hand. The RN said Resident #1 was unable to tell her what happened, and he had dementia and previous stokes and baseline of confusion with mumbling of inappropriate words. The critical care RN said the hospital was concerned because Resident #1 was contracted and immobile. She said she called the facility and spoke initially with MDS RN F who only read her a nursing progress note and did not have any further information. Then the DON called her 30 minutes later and did not believe it was a burn. The critical care RN said, Anyone can tell it is a burn. They did a dry dressing which was not appropriate, it should have been a wet dressing. She said if a dry dressing is applied to a burn such as Resident #1's, essentially it would stick to the wound and worsen it when it was removed. The critical care RN said she asked the DON why they chose that dressing and the DON responded they had notified the wound care nurse. The critical care RN said, I did tell the DON I thought it was a burn and asked if he had any new oils or lotions, hot water exposure and she told me this was first noticed in the middle of the night on the 24th by an aide, so that is the note that was read to me .This is pretty significant. She said when she told the DON about the burn, the DON replied that she had asked Resident #1 if he was in pain, and he said no. The critical care RN said, My thing is he won't even tell you his name. He has dementia. He is not going to do this to himself. The critical care RN said, He came in septic, this poor man, I feel bad .it made me so mad. The critical care RN said she felt Resident #1 had an injury of unknown origin and it was suspicious because it was not an injury that he could do to himself. Review of Resident #1's hospital records revealed he arrived at the hospital emergency department on 07/25/22 at 8:06 AM and was tachycardic (a heart rate over 100 beats a minute) to 170's, blisters and loss of epithelial skin (the tissue which covers the internal and external surfaces of the body) on the dorsum (the corresponding area on the top part of the hand) of the left hand consistent with possible burns and his upper extremities were contracted. The ED's attending note stated, Patient was sent from a nursing home for elevated heart rate, was reported that yesterday he sustained some blisters on his hand from an unknown process. The ED medical doctor's final impression/diagnosis was, Atrial fibrillation with RVR (when the rapid contractions of the atria make the ventricles beat too quickly), urinary tract infection with hematuria (the presence of blood in a person's urine), site unspecified, pneumonia of right lung to infectious organism, unspecified part of lung, and burn. A request was made for wound care to assess his left hand due to it appearing to be a burn but unable to ascertain a source. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he presented to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat source to the body, causing an increase in the temperature of local tissue) with blisters on his left hand and fingers. He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1) 2 Palmar (palm of the hand) blisters superior to the palmar crease; blisters of [NAME] 5th digit (finger) over phalanges (the group of small bones that comprise the bony core of the digits (fingers) of the hand), blister on 4th digit fingertip and over middle phalanx (a bone of the finger); 2) 2nd degree burns of the dorsal (top) wrist and hand with absent epidermis (skin) several bullae (large blisters on the skin that are filled with clear fluid) including tubular bulla of dorsal 1st webspace, hemorrhagic blister (when blood pools and forms a blister) in 1st webspace, several small bullae over proximal (situated near) 4th and 5th digit, bulla of 4th digit middle phalanx. He was noted to be neurological confused and unable follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal bacitracin ointment, adaptic/xeroform, ABD pad and loose Kerlix wrap and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. An interview with the overnight nurse, LVN A, on 07/28/22 at 11:56 AM revealed she had worked at the facility Saturday 2pm-10pm and the overnight shift (07/23/22) and on Sunday (07/24/22) she worked the overnight shift 10 PM-6 AM. LVN A said she was notified by a CNA in the early morning hours before the overnight shift was over Sunday morning (07/25/22) that the CNA was getting him up and noticed issues with his skin and she wanted LVN A to look at it. When LVN A went to his room, Resident #1 initially had a big blister right on top of his hand that had popped and little one right next to it that had not popped but one was draining . She said the skin was still on so she did not want to aggressively rub it and she covered it with a dry dressing and put it on the 24 hour report to remind herself. LVN A said they left him in bed at that time. LVN A said she did not contact MD E or an on-call doctor on Sunday 07/24/22 when she first noticed Resident #1's left hand injuries because the facility lets the treatment nurse look at it first. LVN A said she just cleaned it and wanted the wound nurse to look at it when she came in. She said the wound nurse did not normally work the weekends and that was why she made a note in the 24-hour report to remind herself and alert the oncoming nurse to follow up. However, she said Resident #1 was sent out to the ER the next day in the early morning before the wound care nurse could look at his hand. When LVN A came back to work later that day for her overnight shift (Sunday into Monday 07/24/22-07/25/22), she was rounding and when she looked at the dressing, it looked like it had dried so she changed it. When she unwrapped it, there were triple the amount of new blisters around the entire hand, like big, huge blisters which were not there the day before so the blisters tripled in numbers in 24 hours, and they were on the palm of his hand. LVN A said she cleaned it, wrapped his hand with a dry dressing and texted the DON asking her what to do. She said, As far as I know, there was nothing that had burned him, but the wound was growing. At that point, she called MD E and told him about it for the first time. He said initially he would refer to a dermatologist, but then said to send Resident #1 to the ER in case he had something contagious since it came on that rapidly. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on 07/28/22 at 2:26 PM revealed the facility did not contact the wound care physician to have he/she assess Resident #1's left hand injury because the resident had already been sent out to the hospital. She also stated there was no wound care nurse working on the weekend. The DON said she believed MD E was notified about Resident #1 on Sunday 07/24/22 prior to her arriving at the facility by LVN A. The DON said she was at the facility that day, arriving early in the morning around 6am because she needed to swab residents for COVID-19 due to a recent positive case. She said thought LVN A notified MD E. However, the DON said she did not verify that LVN A called him and did not follow up with her afterwards to see what his orders were. She said she had just assumed LVN A called MD E and she had no idea why she did not call him. The DON said she first saw Resident #1' hand when she arrived that morning around 7AM and when she went to his room, she saw the blisters on his left hand before they erupted. She said he had no indicators of pain and there was no other issues with his skin other than his left hand. The DON said she did not tell LVN A to contact the doctor (MD E) and had assumed she had already done that. An observation and attempted interview of Resident #1 occurred on 08/15/22 at 3:30 PM while he was in his hospital room. Resident #1's eyes were closed but he was awake. He was initially not responsive to questions. Upon increasing the volume of the voice, he stirred and moved his head, but his responses to questions were minimal, with only making a sound each time, no discernable words. His blood pressure was 178/93, pulse 58. The hospital RN unwrapped his left hand to procced with a dressing change. Resident #1 did not wince or make any motions or sounds of discomfort. His left hand was observed to be in a state of healing. There were no more liquid-filled blisters, but the scarring could be seen on his knuckles where the blisters were and on his palm of his hand and the top of his hand and in the webbing of his fingers. The skin had grown back over the top of his hand, however, it was lighter in color than the other surrounding skin. There were no open areas noted. The hospital RN said it looked like Resident #1 may of had something hot poured on top of his hand and it had dripped down and around through his fingers to the underside of his palm, but since she was not present to observe the injury happen, she was only speculating. Review of the facility's policy titled, Notifying the Physician of Significant Change in Status revised March 2013, reflected, The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention; 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record; .3 .The nurse is responsible, however, for responding to a change in condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record; .6. The nurse will monitor and reassess the resident's status and response to interventions. Physicians should develop a working diagnosis and guide the nursing staff in what to monitor, and when to notify the physician if the resident's condition does not improve . On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received the IJ template on 08/16/22 at 2:21 PM. The Plan of Removal (POR) was accepted on 08/17/22 at 2:49 PM and reflected: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Facility Name-Plan of Removal 8/16/2022 1. F580 - Failure to Notify Physician Resident #1 was found with a change in condition to his left hand (blistered all over top and bottom of hand with skin on top gone) on Sunday 07/24/22 in the early morning hours by a CNA when doing incontinent care. He was assessed by the DON and LVN promptly who felt he did not have a burn, but a change in skin condition and put a dry bandage on his hand. The physician was not notified of the change in condition and treatment orders were not obtained at that time. Next morning, Resident #1's dressing was removed, and blisters had tripled in size. Doctor notified at that time and sent resident to ER. At hospital, resident evaluated and found to have 2nd degree thermal (which means burn came from external heat source) burns to his left hand, UTI and sepsis. Noted: Resident #1 cognitive status is considered impaired by having a diagnosis of Unspecified Dementia without Behavioral Disturbances. Resident #1 has contractures, and his care needs are total dependence for ADL's which include dressing, bathing, grooming, eating, transferring, bed mobility, and wheelchair mobility. [CNA D] reported to [LVN A] of the observed skin altercation. A skin sweep was performed by [RN Q and LVN G] on 8/17/22 on 8/17/22 and the nurses' identified residents with dryness to bilateral lower extremities. Nurse contacted [MD E] to notify and obtained orders for treatments. Responsible Parties were notified. Clinical Compliance Nurse [CC-RN] will: - On 8/16/2022, a re-education of identifying injury of unknown origin; different types of burns; thermal burns and how they can occur; notifying physician of change in condition; protocols to obtain treatment orders for skin alteration/ skin injuries, failure to report injury of unknown origin according to federal regulations and state guidelines to the appropriate authorities and investigating injuries of unknown origins including potential causes of the injury to the Director of Nursing. -On 8/16/2022, a re-education of identifying injuries of unknown origin, different types of burns; and notifying physician of change of condition for a resident, failure to report injury of unknown origin according to federal regulations and state guidelines to the appropriate authorities and investigating injuries of unknown origins including potential causes of the injury to the Administrator. Director of Nursing/Designee will: - Complete a skin assessment on current residents by 8/17/2022. - Identified new skin alterations and or signs of injury - facility will follow risk management protocol. Risk management protocol includes completing incident report, notifying physician, executing physician orders obtained, and notifying responsible party by 8/17/2022. - Facility staff will be re-educated on identifying injury of unknown origin; different types of burns, thermal burns and how they can occur by 8/17/2022. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Additionally, Licensed Nurses will be re-educated on notifying the physician for a change in condition and protocols to obtain treatment orders for skin alterations/skin injuries by 8/17/2022. - Any staff member not receiving this education by 8/17/2022 will be educated prior to next scheduled shift. An employee roster and schedule will be used to validate education compliance. Facility per diem nurses, new hires, and agency nurses will receive this re-education prior to reporting for duty. - Findings will be addressed at the time of discovery and presented to the facility Quality Assurance Performance Improvement monthly x 3 months through December 2022. - Facility Designee or Administrator will ensure compliance and monthly reporting to Quality Assurance and Performance Improvement (QAPI) . Monitoring interviews for the Immediate Jeopardy were started on 08/17/22 at 10:50 AM and continued through 08/17/22 at 4:30 with 15 staff across all three shifts , including weekdays and weekends, from the nursing, administration, dietary and housekeeping departments. The staff were interviewed about procedures related to change of condition, injuries of unknown origin, notification to ADM, thermal injuries and how they can occur, notification to the physician, obtaining treatment orders, abuse and neglect, and hot water (showers)/liquids (drinks) parameters. Staff were able to verbalize understanding of the training received. Additionally, the Corporate Regional Clinical RN provided an in-service done with the DON and ADM on 08/17/22 related to thermal burn identification, intervention and notification to the physician, obtaining treatment orders, recognizing a change in condition, recognizing an injury of unknown origin, as well as reporting injuries of unknown origin to HHSC and investigating. The following staff's in-service logs and competency tests were reviewed and they were interviewed during the monitoring time frame and were able to articulate what they had been taught, protocols and procedures related to change of condition, injuries of unknown origin, notification to ADM of injuries of unknown origin, thermal burn injuries and how they could occur, notification to the physician, obtaining treatment orders, abuse and neglect, and hot water (showers)/liquids (drinks) parameters: CNA G, RN H, CNA I, Hkpg J, BOM, CNA K, LVN B, Cook L, Laundry Aide M, Med Aide N, LVN O, ADON P, MDS RN F, ADM and DON. Monitoring and review of all resident skin assessments completed by the facility nurses on 08/16/22 and 08/17/22 revealed all residents were checked for any changes to skin, to include reddened areas that remained after pressure reduction, rashes, bruises open lesions, cuts lacerations and skin tears, blisters, open ulcers, dry or flaky skin and edema. No residents were found to have any injuries of unknown origin, including burns. 19 residents were assessed as having dry and/or flaky skin. For those residents, the physician was notified, and an order was obtained for Eucerin (emollient) for bilateral lower extremities and/or feet. The facility's ADM was notified the IJ was removed on 08/17/22 at 4:35 PM. While the Immediate Jeopardy was removed on 08/17/22, the facility remained out of compliance due to the facility's need to evaluate the effectiveness of the Plan of Removal.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and establish policies and procedures to investigate any such allegations for one (Resident #1) of five residents reviewed for abuse, neglect, and exploitation. The facility staff failed to investigate an injury of unknown origin of Resident #1 when the resident was found to have a significant injury to his left hand, and whose source could not be identified by the facility. Resident #1 had to be sent to the ER the following day when he became unresponsive and the blisters had tripled in size, where he was diagnosed with second degree thermal burns to his whole left hand, sepsis and a urinary tract infection. The hospital notified the facility that there was a concern that the resident had been burned. The facility abuse/neglect coordinator did not initiate an provider investigation. This failure could place the residents at risk for further potential abuse due to uninvestigated allegations of abuse, neglect, and injuries of unknown origin. On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received the IJ template on 08/16/22 at 2:21 PM. Findings included: Review of facility's Abuse/Neglect policy revised 08/28/17, reflected, .The Abuse Preventionist will be responsible for receiving, leading the appropriate investigation, assure that required reporting is completed timely . Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (A broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of skin breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting resident dressed this morning, aide notified nurse of skin issues. On top of resident's left hand was cluster of blisters, with the biggest one observed to have opened up on the top of his left hand. Other smaller blisters observed over left finger areas. Hand cleaned and covered with dry dressing and wound care notified. Called and left voicemail for RP. Review of Resident #1's nursing notes the next day on 07/25/22 at 7:31 AM written by LVN A reflected, While doing rounds at the end of shift, this nurse went to check on resident, dressing to left hand appeared slightly wet so nurse unwrapped it to assess before re-wrapping it. When dressing was taken off, this nurse noted existing rosy, red area to top of hand where the first blister had burst open the morning before. No drainage however noted to this area. To surrounding area was however noted multiple huge new clear fluid filled blisters around existing area, on all left fingers and knuckles, and two large blisters on the left palm of his hand. When nurse asked resident if he was in pain, he said no .MD notified immediately and order given to transfer to ER for further eval and to rule out any possible infections/contagious issues .While gathering resident's paperwork while resident was seated at the nurses' station, resident noted to become verbally unresponsive despite being given the sternal rub and was being shaken many times. Review of the facility's incident and accident logs for July 2022 revealed Resident #1 was not listed. Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the hospital critical care RN on -7/28/22 at 12:37 PM revealed Resident #1 was presently at the hospital and had been diagnosed with second degree burns to his left hand, sepsis and a UTI. The RN said when she first saw Resident #1's left hand, she was re-wrapping it to do wound care. He had blistering and a large open to the back of his left hand and blistering to the front and back down to where the wrist started. His skin on the left hand was blistered with a giant open area to the back of the hand that was red and granulated, blistering to all four digits and thumb on the outside and palm side of the hand. She said there were no more skin issues beyond the left hand. The RN said Resident #1 was unable to tell her what happened and he had dementia and previous stokes and baseline of confusion with mumbling of inappropriate words. The critical care RN said the hospital was concerned because Resident #1 was contracted and immobile. She said she called the facility and spoke initially with MDS RN F who only read her a nursing progress note and did not have any further information. Then the DON called her 30 minutes later and did not believe it was a burn. The critical care RN said, I did tell the DON I thought it was a burn and if he had any new oils or lotions, hot water exposure and she told me this was first noticed in the middle of the night on the 24th by an aide, so that is the note that was read to me .This is pretty significant. She said when she told the DON about the burn, the DON replied that she had asked Resident #1 if he was in pain and he said no. The critical care RN said, My thing is he won't even tell you his name. He has dementia. He is not going to do this to himself. The critical care RN said, He came in septic, this poor man, I feel bad .it made me so mad. The critical care RN said she felt Resident #1 had an injury of unknown origin and it was suspicious because it was not an injury that he could do to himself. Review of Resident #1's hospital records revealed he arrived at the hospital emergency department on 07/25/22 at 8:06 AM and was tachycardic (a heart rate over 100 beats a minute) to 170's, blisters and loss of epithelial skin (the tissue which covers the internal and external surfaces of the body) on the dorsum (the corresponding area on the top part of the hand) of the left hand consistent with possible burns and his upper extremities were contracted. The ED's attending note stated, Patient was sent from a nursing home for elevated heart rate, was reported that yesterday he sustained some blisters on his hand from an unknown process. The ED medical doctor's final impression/diagnosis was, Atrial fibrillation with RVR (when the rapid contractions of the atria make the ventricles beat too quickly), urinary tract infection with hematuria (the presence of blood in a person's urine), site unspecified, pneumonia of right lung to infectious organism, unspecified part of lung, and burn. A request was made for wound care to assess his left hand due to it appearing to be a burn but unable to ascertain a source. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he presented to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat source to the body, causing an increase in the temperature of local tissue) with blisters on his left hand and fingers. He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1) 2 Palmar (palm of the hand) blisters superior to the palmar crease; blisters of [NAME] 5th digit (finger) over phalanges (the group of small bones that comprise the bony core of the digits (fingers) of the hand), blister on 4th digit fingertip and over middle phalanx (a bone of the finger); 2) 2nd degree burns of the dorsal (top) wrist and hand with absent epidermis (skin) several bullae (large blisters on the skin that are filled with clear fluid) including tubular bulla of dorsal 1st webspace, hemorrhagic blister (when blood pools and forms a blister) in 1st webspace, several small bullae over proximal (situated near) 4th and 5th digit, bulla of 4th digit middle phalanx. He was noted to be neurological confused and unable follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal bacitracin ointment, adaptic/xeroform, ABD pad and loose Kerlix wrap and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. Review of TULIP database on 07/27/22 revealed no evidence of a provider investigation report or a provider investigation for Resident #1's injury of unknown origin. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on 07/27/22 at 3:00 PM revealed Resident #1 was sent to the hospital because his hand needed to be looked at by a higher level. She said MDS RN F had talked to the critical care hospital RN the day before (07/26/22) who had implied that Resident #1 had been burned or abused. The DON then called the hospital RN because of her feeling the resident was abused and told her it was a skin issue, not abuse. The DON said she took a picture of Resident #1's left hand on Monday morning when he was sent out. She said his left hand was red with a cluster of blisters that had erupted. She said, Initially we had thought maybe this was cellulitis. She then said, When I saw it like this (showed her phone of Resident #1's left hand), I told [MD E] it was not presenting as cellulitis. She said MD E did not visit Resident #1 in person after being notified on Day 2 of the blisters and she did not send him the picture that she took of Resident #1's hand. The DON said when she saw how much bigger the blisters had gotten on the second day, was when Resident #1 was sent out for further evaluation. The DON said she felt it was some kind of infection, I think. The DON said she did not know how Resident #1 was doing while at the hospital. She said he was not interviewable and sometimes made grunts or would moan when he was in pain, but he did not talk at all. The DON said Resident #1 was not ambulatory, was almost max dependence on ADLs and he was bed bound and wheelchair bound. She said he never went out on pass and rarely had family visitors. The DON said a burn would definitely be red and raw, it could have some black areas around it, and around the edges it would be white with moisture associated skin damage from the resident's own fluid leaking out from the edge of the wound and it would be extremely painful and in various stages all the way to 3rd degree. She said what happened with Resident #1, happened very acutely, very fast. The DON said an incident report was not done because it was never anything to warrant an incident, it was not a wound or injury. She said a wound care nurse or doctor did not look at it and the blisters all happened within 24 hours. The DON said, I know it is not a burn because those blisters did not present like it was a burn. I have seen fluid filled blisters like that, that were not related to burn. That looked like a fluid infection going on in his body. She said the blisters were fluid filled and were small and rapidly grew over the course of that day. She said Resident #1 could not tell them anything about what happened but he could respond to painful stimuli and he never presented with any pain or tearfulness or guardedness. An interview with MDS RN F on 07/27/22 at 3:15 PM revealed the hospital critical care RN had called to find out what happened to Resident #1's hand and said his whole hand was burned. MDS RN F did not know details about it, so she read the progress notes to the hospital critical care RN and then told the DON about the call because the hospital RN sounded disbelieving. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LVN B on 07/28/22 at 10:51 AM revealed she did not see Resident #1 over the weekend of 07/23/22 and 07/24/22 but did see him when she arrived at work on Monday 07/25/22. LVN B said his skin was clear when she left work on Friday 07/22/22 but when she came back on 07/25/22, he had one big blister on the top of his left hand that had already busted and the night nurse (LVN A) was not sure what it was and no one could understand how he got blisters like that. LVN B said she did not know if it was a burn because something real hot would have had to caused it. She said Resident #1's index finger was really swollen and he had a blister on the pointer finger side going towards the thumb. LVN B said Resident #1 normally could talk, but he was not there at all, she shook him, called his name and tried to open his eyes to get a reaction, but he was not responding, which was unusual. She said he could not tell her if he was in pain. She said by that time, the overnight nurse (LVN A) had notified the DON and physician to see what they wanted to do and MD F said to send him out since no one knew what had happened. LVN B said after that, she googled burn blisters on the hand and the pictures on the internet looked like Resident #1's. LVN B said, But I don't want to say it is a burn, because that is not good. LVN B said she did not know if Resident #1 had an injury of unknown origin. She said that would be when a person could not tell how an injury occurred She then said, We don't know how this one occurred. A follow up interview with MDS RN F on 07/28/22 at 11:17 AM revealed she had been employed at the facility for a month and she was the RN manager on duty on Sunday 07/24/22 and had come to the facility last in the morning around 11 AM. She said she had not been notified of any issues related to Resident #1 but as the MOD, she went to each nurses' station, asked how things were going, if there were any new incidents and accidents and she was told no. She then went to the MDS office and did assessments and later helped serve dinner. She said she did not see Resident #1's hand. MDS RN F said she was first made aware of Resident #1's hand during the morning management meeting on Monday 07/25/22, after he had already been sent out. MDS RN F said an injury of unknown origin was something that was abnormal, that was not there before. If that occurs, the facility should look into what happened and start an investigation, see if it was suspicious. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the overnight nurse, LVN A, on 07/28/22 at 11:56 AM revealed she had worked at the facility Saturday 2pm-10pm and the overnight shift (07/23/22) and on Sunday (07/24/22) she worked the overnight shift 10 PM-6 AM. LVN A said she was notified by a CNA in the early morning hours before the overnight shift was over Sunday morning (07/25/22) that the CNA was getting him up and noticed issues with his skin and she wanted LVN A to look at it. When LVN A went to his room, Resident #1 initially had a big blister right on top of his hand that had popped and little one right next to it that had not popped but one was draining. She said the skin was still on so she did not want to aggressively rub it and she covered it with a dry dressing and put it on the 24 hour report to remind herself. LVN A said they left him in bed at that time. LVN A said she did not contact MD E or an on-call doctor on Sunday 07/24/22 when she first noticed Resident #1's left hand injuries because the facility lets the treatment nurse look at it first. LVN A said she just cleaned it and wanted the wound nurse to look at it when she came in. She said the wound nurse did not normally work the weekends and that was why she made a note in the 24 hour report to remind herself and alert the oncoming nurse to follow up. However, she said Resident #1 was sent out to the ER the next day in the early morning before the wound care nurse could look at his hand. When LVN A came back to work later that day for her overnight shift (Sunday into Monday 07/24/22-07/25/22), she was rounding and when she looked at the dressing, it looked like it had dried so she changed it. When she unwrapped it, there were triple the amount of new blisters around the entire hand, like big, huge blisters which were not there the day before so the blisters tripled in numbers in 24 hours, and they were on the palm of his hand. LVN A said she cleaned it, wrapped his hand with a dry dressing and texted the DON asking her what to do. She said, As far as I know, there was nothing that had burned him, but the wound was growing. At that point, she called MD E and told him about it for the first time. He said initially he would refer to a dermatologist, but then said to send Resident #1 to the ER in case he had something contagious since it came on that rapidly. LVN A said, I don't know if he was reacting to anything or if he was burned. LVN A said she did not initially think it was a burn because no one had mentioned anything to her, But with the tripling of them (the blisters) the next day, with the wound wrapped up, I don't know. LVN A said an injury of unknown origin was when a person did not know how it occurred. Observation and record review of the 24-hour book for Hall 100 (Resident #1's hall) revealed no entries on 07/23/22 or 07/24/22 related to the resident. An interview with the wound care LVN G on 07/28/22 at 07/28/22 at 3:10 PM revealed that Resident #1 had not been on her caseload and she did not work over the weekend on 07/23/22-07/24/22. She said no one mentioned anything to her about Resident #1's hand and he had already been sent to the hospital by the time she arrived at work Monday 07/25/22. She said she only found out about it through hearing people talking about it conversationally in the facility. Wound Care LVN G said a burn could present differently, depending on the degree of it. She said there could be blistering, discoloration, redness, some swelling due to the degree, and some skin may be missing due to the degree of the burn. She said most second degree burns were blistered and a burn could re-blister, pop on their own and come back up. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA C on 07/28/22 at 12:25 PM revealed she had last seen Resident #1 on Friday 07/22/22 and his skin looked great, she could see his hands when she laid him down. When she saw him Monday morning 07/25/22, she was told that he maybe had an infection because his hand was wrapped. CNA C said then the overnight nurse, LVN A took off the dressing and she saw he had pink raw skin on top of his hand. She said she was wondering how that could have happened because Resident #1 always kept his hands balled up and only moved them to itch his face. CNA C described Resident #1's left hand as looking like person who got burned, because she had never seen an infection that took the skin off like that and that he had blisters everywhere on his fingers and palm. Resident #1 could not tell her what happened because he was blind and only spoke a few words and he was not responsive, which was not normal. CNA C said, I said y'all sure it not a burn and they were like shhhhh (be quiet sound) .at the same time I was like what if this is your family member? She said when Resident #1 was not responding to her, she tried to do a sternal rub, But nothing, like he was losing it. CNA C said she told the DON that she should take staff members off the schedule who had worked with Resident #1 before that time frame just in case, and investigate, and she just looked at me. She said, If it was my family member, I would want to know the facility is looking into it. An interview with CNA D on 07/28/22 at 3:58 PM revealed she had worked the overnight shift for the first time on Resident #1's hall on Saturday-Sunday shift (07/23/22-07/24/22), but she knew him from working with him on another hall. She said on that overnight shift, around 3:50 AM, she went in to check on him and he was quiet and she was worried he was not breathing but then looked closer and saw his chest was rising. She said he was a typically a heavy soil and outputs a lot and the entire night when she would go and check on him, he was dry up until 3:50 AM and that was unusual. CNA C said incontinence being not as frequent or not as much as it used to be could be a sign of the body shutting down. She said Resident #1 had not voided at all her shift until then. When she changed him, it was only urine and it could fill her palm so it was not much and he was laying on his hand so she turned him over. When CNA C turned him over, there was a thin brown layer of something next to him. She did not know what it was. She picked it up and then looked at this hand and saw the entire left layer of skin on his left hand was missing. She said, I was like oh my god, I lifted up his hand and he groaned when I lifted it up and it looked like he had been burned. CNA C then went to LVN A and asked what happened because it looked fresh because his fingers where white in color, like being in water too long but he was African American. She said Resident #1's hand was soggy and there were huge blisters all over his hand and fingers. CNA C said she had picked up the piece of his hand skin unknowingly, so she told LVN A. CNA C said Resident #1 was severely injured and he could not walk, see, or move his arms more than to his face, he was stuck in the fetal position and he could not have burned himself. She said LVN A wrapped his hand temporarily because there was puss on his hand. CNA C said Resident #1 did seem to be in pain, like the injury was hurting him. She said when she and LVN A pulled his hand up and started to wipe it down before it was wrapped, he was making little groans. CNA D said she felt like LVN A was not being responsive and CNA C was panicked because she had residents get hurt in front of her before and pass away, so Resident #1's hand made her emotional. She said, Someone that cannot move, cannot do this to themselves. I try not to freak out but there was no sense of urgency or care. When she (LVN A) wrapped his hand too, she didn't clean it, just put on a gauze pad and wrapped it real quick. I was like, just dry gauze on the open flesh, it will stick when you take it off. CNA D said LVN A did not talk to her the rest of the shift and CNA D later talked to the DON about her concerns and not wanting to work with that nurse again or on that hall. CNA D said the DON did make any inquiries into Resident #1's hand. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow up interview with the DON on 07/28/22 at 2:26 PM revealed she first saw Resident #1's hand on Sunday, 07/24/22 around 7AM because she had to swab him to test for COVID-19. LVN A had already seen his hand and the DON had been notified. When she went to his room, she saw the blisters on his left hand before they erupted. She said he had no indicators of pain and there was no other issues with his skin other than his left hand. The DON said she could not remember when she notified the ADM about Resident #1's hand. The DON said an injury of unknown origin was one that could not be described as to where it came from. She said she did not feel Resident #1 had an injury of unknown origin, she felt it was an infection, not an injury. She claimed no one from the hospital indicated to her that it was a burn. The DON said a nurse was not supposed to diagnose a resident, they can describe the situation to the physician. She said she did not talk to MD E on Sunday 07/24/22 so she did not describe Resident #1's skin change/injury to him, I assumed he had already been called. The DON said the injury did not qualify to be called to HHSC as a self-reported incident by the Abuse and Neglect Coordinator because it presented as an infection and Resident #1 had the ability to let them know if he was in pain, and he was not, and a burn would be extremely painful. The DON said if she had been notified from the hospital that the resident had second degree burns, then she would have notified the ADM and it would be reported to HHSC and an investigation would be started. An interview with MD E on 07/28/22 at 3:32 PM revealed he was the medical director for the facility and attending physician to Resident #1. He said he vaguely remembered being contacted by the facility Monday morning on 07/25/22 and they were asking him about the lesions he had which was a bug deal with Monkey Pox going on. He said the facility had no cases of Monkey Pox but it was number one on his list to watch out for and he did not want it to get loose in the facility so he wanted Resident #1 sent out. He said no one from the facility mentioned it could have been a burn and no one contacted him when the injury was first identified on Sunday 07/24/22 for a change in condition. MD E said, If a resident has big blisters all over his hand, they should have notified me for sure. I would have needed a description of the lesions. He said, A lot of times, I am not sure if the nurses are sure of what they are looking at or seeing. MD E said he remembered being sent a photo of Resident #1's hand on 07/25/22 and that was the reason he sent him out, when he saw it. MD E said she would consider something an injury of unknown origin is the facility did not have any indications of what caused the injury and could not identify any infections or inflammatory issues. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the ADM on 07/28/22 at 2:48 PM revealed she was the facility abuse and neglect coordinator and she investigated allegations to determine if there was abuse or not. In the same role, she reported any suspicious injuries and initiated investigations and resolved them one way or another. In that process, the ADM said she may suspend staff or implement things as a result of the allegation. The ADM said she was first told about Resident #1's injury when the DON said she was sending him out Monday morning on 07/25/22. She told the ADON it had something to do with a disease, or whatever disease state he was in, but the ADM could not state what that disease was and she did not ask. The ADM said no one notified her about the injury on Sunday 07/24/22 when the blistering was initially seen. If it was a burn, the ADM said the DON should have let her know, If it was an injury of unknown origin, absolutely. At the stand-up meeting on Monday 07/25/22, the DON stat So Monday, the DON said Resident #1 had been sent out already and that he had some blisters and they were not out of the norm of expectations from his diagnosis of whatever that is. The ADM said she had just seen the picture taken by LVN A of Resident #1's left hand. The ADM said, I have never seen that before in my life. They tried to show it to me before but I have a weak stomach. I will say I just need your clinical expertise. So when I saw the picture, when I saw the blisters, I was like what is that? She said the DON told her she had seen it before and there were some diseases that when there is a flare up and the body has nowhere to release those toxins, they could come out like that. The ADM stated, So I relied on her, my DON because this was a clinical issue, to let me know if this was a reportable incident to State. I asked during morning meeting too in on Monday in front of other staff about whether it was reportable and she said no, it was part of his disease process. So I did not report. The ADM further said after the admission to the hospital, a hospital nurse called and talked to MDS RN F and the MDS RN F came to her and said the hospital was inferring that he had been burned. That was when the ADM said she went to the DON and she said she would call the hospital and tell them it was not a burn. The ADM said she did not discuss Resident #1's injury with anyone else, just the DON. She said she did not call corporate for counsel on whether to report it to HHSC as an injury of unknown origin and possible abuse/neglect. An interview with the CC-RN on 08/15/22 at 11:15 AM revealed he was an ER nurse in the past and had been a nurse for over [AGE] years. He said he trusted the DON's judgement and clinical assessment of Resident #1's hand injury and she did not feel it was a thermal burn. He said she knew what a burn was and he did as well and it did not present as such. CC-RN stated with a thermal burns, the blisters would not be identical in size on the top and palm of the hand and the fingers would be scalded, which they were not. He said in order to have been burned, someone would of had to take Resident #1's contracted hand, open it up, and submerge it into a hot liquid. He said that just was not possible and did not happen. He said the DON knew what a burn was and had she felt it was a burn, she would have reported it to ADM as an injury of unknown origin and proceeded with an investigation. But when she saw it, it was not presenting as a burn. The CC-RN said that he saw the color photos of Resident #1's left hand and he did not feel the resident had a thermal burn injury. He said the hospital was not open to communicating with him (specifically the initial MD evaluator of the burn) and he had spent hours trying to contact them to discuss the injury. The CC-RN said the hospital still continued to send residents to the facility for admission and the plan remained for Resident #1 to come back to the facility when he was discharged . (continued on next page)

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Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Investigating Incidents of Unknown Origin revised January 2020, reflected, The facility will investigate incidents of unknown origin .1. The DON/designee will follow up on the incident report (Gather witness statements, interviewed, follow up on notification of family and physician, ensure completion of documentation, complete the quality assurance review, ensure the incident has been care-planned if required). 2. The incident will be tracked on SOC. 3. The DON/designee will initiated monitoring as indicated. 4. The DON/designee should follow up on the documentation daily until the investigation is complete. 5. Once investigation is completed, the documentation should be reviewed by the QAPI team. On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effect [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident's property for one (Resident #1) of five residents reviewed for abuse, neglect, and exploitation. The facility staff failed to report an injury of unknown origin of Resident #1 to HHSC when the resident was found to have a significant injury to his left hand, and whose source could not be identified by the facility. Resident #1 had to be sent to the ER the following day when he became unresponsive and the blisters had tripled in size, where he was diagnosed with second degree burns to his whole left hand, sepsis and a urinary tract infection. This failure could place the residents at risk for further potential abuse due to unreported and uninvestigated allegations of abuse, neglect, and injuries of unknown origin. Findings included: Review of facility's Abuse/Neglect policy revised 08/28/17, reflected, .The Abuse Preventionist will be responsible for receiving, leading the appropriate investigation, assure that required reporting is completed timely . Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (A broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period. Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of skin breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting resident dressed this morning, aide notified nurse of skin issues. On top of resident's left hand was cluster of blisters, with the biggest one observed to have opened up on the top of his left hand. Other smaller blisters observed over left finger areas. Hand cleaned and covered with dry dressing and wound care notified. Called and left voicemail for RP. Review of Resident #1's nursing notes the next day on 07/25/22 at 7:31 AM written by LVN A reflected, While doing rounds at the end of shift, this nurse went to check on resident, dressing to left hand appeared slightly wet so nurse unwrapped it to assess before re-wrapping it. When dressing was taken off, this nurse noted existing rosy, red area to top of hand where the first blister had burst open the morning before. No drainage however noted to this area. To surrounding area was however noted multiple huge new clear fluid filled blisters around existing area, on all left fingers and knuckles, and two large blisters on the left palm of his hand. When nurse asked resident if he was in pain, he said no .MD notified immediately and order given to transfer to ER for further eval and to rule out any possible infections/contagious issues .While gathering resident's paperwork while resident was seated at the nurses' station, resident noted to become verbally unresponsive despite being given the sternal rub and was being shaken many times. Review of the facility's incident and accident logs for July 2022 revealed Resident #1 was not listed. Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75. An interview with the hospital critical care RN on 7/28/22 at 12:37 PM revealed Resident #1 was presently at the hospital and had been diagnosed with second degree burns to his left hand, sepsis and a UTI. The RN said when she first saw Resident #1's left hand, she was re-wrapping it to do wound care. He had blistering and a large open to the back of his left hand and blistering to the front and back down to where the wrist started. His skin on the left hand was blistered with a giant open area to the back of the hand that was red and granulated, blistering to all four digits and thumb on the outside and palm side of the hand. She said there were no more skin issues beyond the left hand. The RN said Resident #1 was unable to tell her what happened and he had dementia and previous stokes and baseline of confusion with mumbling of inappropriate words. The critical care RN said the hospital was concerned because Resident #1 was contracted and immobile. She said she called the facility and spoke initially with MDS RN F who only read her a nursing progress note and did not have any further information. Then the DON called her 30 minutes later and did not believe it was a burn. The critical care RN said, I did tell the DON I thought it was a burn and if he had any new oils or lotions, hot water exposure and she told me this was first noticed in the middle of the night on the 24th by an aide, so that is the note that was read to me .This is pretty significant. She said when she told the DON about the burn, the DON replied that she had asked Resident #1 if he was in pain and he said no. The critical care RN said, My thing is he won't even tell you his name. He has dementia. He is not going to do this to himself. The critical care RN said, He came in septic, this poor man, I feel bad .it made me so mad. The critical care RN said she felt Resident #1 had an injury of unknown origin and it was suspicious because it was not an injury that he could do to himself. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's hospital records revealed he arrived at the hospital emergency department on 07/25/22 at 8:06 AM and was tachycardic (a heart rate over 100 beats a minute) to 170's, blisters and loss of epithelial skin (the tissue which covers the internal and external surfaces of the body) on the dorsum (the corresponding area on the top part of the hand) of the left hand consistent with possible burns and his upper extremities were contracted. The ED's attending note stated, Patient was sent from a nursing home for elevated heart rate, was reported that yesterday he sustained some blisters on his hand from an unknown process. The ED medical doctor's final impression/diagnosis was, Atrial fibrillation with RVR (when the rapid contractions of the atria make the ventricles beat too quickly), urinary tract infection with hematuria (the presence of blood in a person's urine), site unspecified, pneumonia of right lung to infectious organism, unspecified part of lung, and burn. A request was made for wound care to assess his left hand due to it appearing to be a burn but unable to ascertain a source. Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he presented to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat source to the body, causing an increase in the temperature of local tissue) with blisters on his left hand and fingers. He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1) 2 Palmar (palm of the hand) blisters superior to the palmar crease; blisters of [NAME] 5th digit (finger) over phalanges (the group of small bones that comprise the bony core of the digits (fingers) of the hand), blister on 4th digit fingertip and over middle phalanx (a bone of the finger); 2) 2nd degree burns of the dorsal (top) wrist and hand with absent epidermis (skin) several bullae (large blisters on the skin that are filled with clear fluid) including tubular bulla of dorsal 1st webspace, hemorrhagic blister (when blood pools and forms a blister) in 1st webspace, several small bullae over proximal (situated near) 4th and 5th digit, bulla of 4th digit middle phalanx. He was noted to be neurological confused and unable follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal bacitracin ointment, adaptic/xeroform, ABD pad and loose Kerlix wrap and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. Review of TULIP database on 07/27/22 revealed no evidence of a provider investigation report or a provider investigation for Resident #1's injury of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 07/27/22 at 3:00 PM revealed Resident #1 was sent to the hospital because his hand needed to be looked at by a higher level. She said MDS RN F had talked to the critical care hospital RN the day before (07/26/22) who had implied that Resident #1 had been burned or abused. The DON then called the hospital RN because of her feeling the resident was abused and told her it was a skin issue, not abuse. The DON said she took a picture of Resident #1's left hand on Monday morning when he was sent out. She said his left hand was red with a cluster of blisters that had erupted. She said, Initially we had thought maybe this was cellulitis. She then said, When I saw it like this (showed her phone of Resident #1's left hand), I told [MD E] it was not presenting as cellulitis. She said MD E did not visit Resident #1 in person after being notified on Day 2 of the blisters and she did not send him the picture that she took of Resident #1's hand. The DON said when she saw how much bigger the blisters had gotten on the second day, was when Resident #1 was sent out for further evaluation. The DON said she felt it was some kind of infection, I think. The DON said she did not know how Resident #1 was doing while at the hospital. She said he was not interviewable and sometimes made grunts or would moan when he was in pain, but he did not talk at all. The DON said Resident #1 was not ambulatory, was almost max dependence on ADLs and he was bed bound and wheelchair bound. She said he never went out on pass and rarely had family visitors. The DON said a burn would definitely be red and raw, it could have some black areas around it, and around the edges it would be white with moisture associated skin damage from the resident's own fluid leaking out from the edge of the wound and it would be extremely painful and in various stages all the way to 3rd degree. She said what happened with Resident #1, happened very acutely, very fast. The DON said an incident report was not done because it was never anything to warrant an incident, it was not a wound or injury. She said a wound care nurse or doctor did not look at it and the blisters all happened within 24 hours. The DON said, I know it is not a burn because those blisters did not present like it was a burn. I have seen fluid filled blisters like that, that were not related to burn. That looked like a fluid infection going on in his body. She said the blisters were fluid filled and were small and rapidly grew over the course of that day. She said Resident #1 could not tell them anything about what happened but he could respond to painful stimuli and he never presented with any pain or tearfulness or guardedness. An interview with MDS RN F on 07/27/22 at 3:15 PM revealed the hospital critical care RN had called to find out what happened to Resident #1's hand and said his whole hand was burned. MDS RN F did not know details about it, so she read the progress notes to the hospital critical care RN and then told the DON about the call because the hospital RN sounded disbelieving. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN B on 07/28/22 at 10:51 AM revealed she did not see Resident #1 over the weekend of 07/23/22 and 07/24/22 but did see him when she arrived at work on Monday 07/25/22. LVN B said his skin was clear when she left work on Friday 07/22/22 but when she came back on 07/25/22, he had one big blister on the top of his left hand that had already busted and the night nurse (LVN A) was not sure what it was and no one could understand how he got blisters like that. LVN B said she did not know if it was a burn because something real hot would have had to caused it. She said Resident #1's index finger was really swollen and he had a blister on the pointer finger side going towards the thumb. LVN B said Resident #1 normally could talk, but he was not there at all, she shook him, called his name and tried to open his eyes to get a reaction, but he was not responding, which was unusual. She said he could not tell her if he was in pain. She said by that time, the overnight nurse (LVN A) had notified the DON and physician to see what they wanted to do and MD F said to send him out since no one knew what had happened. LVN B said after that, she googled burn blisters on the hand and the pictures on the internet looked like Resident #1's. LVN B said, But I don't want to say it is a burn, because that is not good. LVN B said she did not know if Resident #1 had an injury of unknown origin. She said that would be when a person could not tell how an injury occurred She then said, We don't know how this one occurred. A follow up interview with MDS RN F on 07/28/22 at 11:17 AM revealed she had been employed at the facility for a month and she was the RN manager on duty on Sunday 07/24/22 and had come to the facility last in the morning around 11 AM. She said she had not been notified of any issues related to Resident #1 but as the MOD, she went to each nurses' station, asked how things were going, if there were any new incidents and accidents and she was told no. She then went to the MDS office and did assessments and later helped serve dinner. She said she did not see Resident #1's hand. MDS RN F said she was first made aware of Resident #1's hand during the morning management meeting on Monday 07/25/22, after he had already been sent out. MDS RN F said an injury of unknown origin was something that was abnormal, that was not there before. If that occurs, the facility should look into what happened and start an investigation, see if it was suspicious. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the overnight nurse, LVN A, on 07/28/22 at 11:56 AM revealed she had worked at the facility Saturday 2pm-10pm and the overnight shift (07/23/22) and on Sunday (07/24/22) she worked the overnight shift 10 PM-6 AM. LVN A said she was notified by a CNA in the early morning hours before the overnight shift was over Sunday morning (07/25/22) that the CNA was getting him up and noticed issues with his skin and she wanted LVN A to look at it. When LVN A went to his room, Resident #1 initially had a big blister right on top of his hand that had popped and little one right next to it that had not popped but one was draining. She said the skin was still on so she did not want to aggressively rub it and she covered it with a dry dressing and put it on the 24 hour report to remind herself. LVN A said they left him in bed at that time. LVN A said she did not contact MD E or an on-call doctor on Sunday 07/24/22 when she first noticed Resident #1's left hand injuries because the facility lets the treatment nurse look at it first. LVN A said she just cleaned it and wanted the wound nurse to look at it when she came in. She said the wound nurse did not normally work the weekends and that was why she made a note in the 24-hour report to remind herself and alert the oncoming nurse to follow up. However, she said Resident #1 was sent out to the ER the next day in the early morning before the wound care nurse could look at his hand. When LVN A came back to work later that day for her overnight shift (Sunday into Monday 07/24/22-07/25/22), she was rounding and when she looked at the dressing, it looked like it had dried so she changed it. When she unwrapped it, there were triple the amount of new blisters around the entire hand, like big, huge blisters which were not there the day before so the blisters tripled in numbers in 24 hours, and they were on the palm of his hand. LVN A said she cleaned it, wrapped his hand with a dry dressing and texted the DON asking her what to do. She said, As far as I know, there was nothing that had burned him, but the wound was growing. At that point, she called MD E and told him about it for the first time. He said initially he would refer to a dermatologist, but then said to send Resident #1 to the ER in case he had something contagious since it came on that rapidly. LVN A said, I don't know if he was reacting to anything or if he was burned. LVN A said she did not initially think it was a burn because no one had mentioned anything to her, But with the tripling of them (the blisters) the next day, with the wound wrapped up, I don't know. LVN A said an injury of unknown origin was when a person did not know how it occurred . Observation and record review of the 24-hour book for Hall 100 (Resident #1's hall) revealed no entries on 07/23/22 or 07/24/22 related to the resident. An interview with the wound care LVN G on 07/28/22 at 07/28/22 at 3:10 PM revealed that Resident #1 had not been on her caseload and she did not work over the weekend on 07/23/22-07/24/22. She said no one mentioned anything to her about Resident #1's hand and he had already been sent to the hospital by the time she arrived at work Monday 07/25/22. She said she only found out about it through hearing people talking about it conversationally in the facility. Wound Care LVN G said a burn could present differently, depending on the degree of it. She said there could be blistering, discoloration, redness, some swelling due to the degree, and some skin may be missing due to the degree of the burn. She said most second degree burns were blistered and a burn could re-blister, pop on their own and come back up. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with CNA C on 07/28/22 at 12:25 PM revealed she had last seen Resident #1 on Friday 07/22/22 and his skin looked great, she could see his hands when she laid him down. When she saw him Monday morning 07/25/22, she was told that he maybe had an infection because his hand was wrapped. CNA C said then the overnight nurse, LVN A took off the dressing and she saw he had pink raw skin on top of his hand. She said she was wondering how that could have happened because Resident #1 always kept his hands balled up and only moved them to itch his face. CNA C described Resident #1's left hand as looking like person who got burned, because she had never seen an infection that took the skin off like that and that he had blisters everywhere on his fingers and palm. Resident #1 could not tell her what happened because he was blind and only spoke a few words and he was not responsive, which was not normal. CNA C said, I said y'all sure it not a burn and they were like shhhhh (be quiet sound) .at the same time I was like what if this is your family member? She said when Resident #1 was not responding to her, she tried to do a sternal rub, But nothing, like he was losing it. CNA C said she told the DON that she should take staff members off the schedule who had worked with Resident #1 before that time frame just in case, and investigate, and she just looked at me. She said, If it was my family member, I would want to know the facility is looking into it. An interview with CNA D on 07/28/22 at 3:58 PM revealed she had worked the overnight shift for the first time on Resident #1's hall on Saturday-Sunday shift (07/23/22-07/24/22), but she knew him from working with him on another hall. She said on that overnight shift, around 3:50 AM, she went in to check on him and he was quiet and she was worried he was not breathing but then looked closer and saw his chest was rising. She said he was a typically a heavy soil and outputs a lot and the entire night when she would go and check on him, he was dry up until 3:50 AM and that was unusual. CNA C said incontinence being not as frequent or not as much as it used to be could be a sign of the body shutting down. She said Resident #1 had not voided at all her shift until then. When she changed him, it was only urine and it could fill her palm so it was not much and he was laying on his hand so she turned him over. When CNA C turned him over, there was a thin brown layer of something next to him. She did not know what it was. She picked it up and then looked at this hand and saw the entire left layer of skin on his left hand was missing. She said, I was like oh my god, I lifted up his hand and he groaned when I lifted it up and it looked like he had been burned. CNA C then went to LVN A and asked what happened because it looked fresh because his fingers where white in color, like being in water too long but he was African American. She said Resident #1's hand was soggy and there were huge blisters all over his hand and fingers. CNA C said she had picked up the piece of his hand skin unknowingly, so she told LVN A. CNA C said Resident #1 was severely injured and he could not walk, see, or move his arms more than to his face, he was stuck in the fetal position and he could not have burned himself. She said LVN A wrapped his hand temporarily because there was puss on his hand. CNA C said Resident #1 did seem to be in pain, like the injury was hurting him. She said when she and LVN A pulled his hand up and started to wipe it down before it was wrapped, he was making little groans. CNA D said she felt like LVN A was not being responsive and CNA C was panicked because she had residents get hurt in front of her before and pass away, so Resident #1's hand made her emotional. She said, Someone that cannot move, cannot do this to themselves. I try not to freak out but there was no sense of urgency or care. When she (LVN A) wrapped his hand too, she didn't clean it, just put on a gauze pad and wrapped it real quick. I was like, just dry gauze on the open flesh, it will stick when you take it off. CNA D said LVN A did not talk to her the rest of the shift and CNA D talked to the DON after her shift was over later that morning about her concerns and not wanting to work with that nurse again or on that hall. CNA D said the DON did make any inquiries into Resident #1's hand. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview with the DON on 07/28/22 at 2:26 PM revealed she first saw Resident #1's hand on Sunday, 07/24/22 around 7AM because she had to swab him to test for COVID-19. LVN A had already seen his hand and the DON had been notified. When she went to his room, she saw the blisters on his left hand before they erupted. She said he had no indicators of pain and there was no other issues with his skin other than his left hand. The DON said she could not remember when she notified the ADM about Resident #1's hand. The DON said an injury of unknown origin was one that could not be described as to where it came from. She said she did not feel Resident #1 had an injury of unknown origin, she felt it was an infection, not an injury. She claimed no one from the hospital indicated to her that it was a burn. The DON said a nurse was not supposed to diagnose a resident, they can describe the situation to the physician. She said she did not talk to MD E on Sunday 07/24/22 so she did not describe Resident #1's skin change/injury to him, I assumed he had already been called. The DON said the injury did not qualify to be called to HHSC as a self-reported incident by the Abuse and Neglect Coordinator because it presented as an infection and Resident #1 had the ability to let them know if he was in pain, and he was not, and a burn would be extremely painful. The DON said if she had been notified from the hospital that the resident had second degree burns, then she would have notified the ADM and it would be reported to HHSC and an investigation would be started. An interview with MD E on 07/28/22 at 3:32 PM revealed he was the medical director for the facility and attending physician to Resident #1. He said he vaguely remembered being contacted by the facility Monday morning on 07/25/22 and they were asking him about the lesions he had which was a bug deal with Monkey Pox going on. He said the facility had no cases of Monkey Pox but it was number one on his list to watch out for and he did not want it to get loose in the facility so he wanted Resident #1 sent out. He said no one from the facility mentioned it could have been a burn and no one contacted him when the injury was first identified on Sunday 07/24/22 for a change in condition. MD E said, If a resident has big blisters all over his hand, they should have notified me for sure. I would have needed a description of the lesions. He said, A lot of times, I am not sure if the nurses are sure of what they are looking at or seeing. MD E said he remembered being sent a photo of Resident #1's hand on 07/25/22 and that was the reason he sent him out, when he saw it. MD E said he would consider something an injury of unknown origin is the facility did not have any indications of what caused the injury and could not identify any infections or inflammatory issues. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADM on 07/28/22 at 2:48 PM revealed she was the facility abuse and neglect coordinator and she investigated allegations to determine if there was abuse or not. In the same role, she reported any suspicious injuries and initiated investigations and resolved them one way or another . In that process, the ADM said she may suspend staff or implement things as a result of the allegation. The ADM said she was first told about Resident #1's injury when the DON said she was sending him out Monday morning on 07/25/22. She told the ADON it had something to do with a disease, or whatever disease state he was in, but the ADM could not state what that disease was and she did not ask. The ADM said no one notified her about the injury on Sunday 07/24/22 when the blistering was initially seen. If it was a burn, the ADM said the DON should have let her know, If it was an injury of unknown origin, absolutely. At the stand-up meeting on Monday 07/25/22, the DON stat So Monday, the DON said Resident #1 had been sent out already and that he had some blisters and they were not out of the norm of expectations from his diagnosis of whatever that is. The ADM said she had just seen the picture taken by LVN A of Resident #1's left hand. The ADM said, I have never seen that before in my life. They tried to show it to me before but I have a weak stomach. I will say I just need your clinical expertise. So when I saw the picture, when I saw the blisters, I was like what is that? She said the DON told her she had seen it before and there were some diseases that when there is a flare up and the body has nowhere to release those toxins, they could come out like that. The ADM stated, So I relied on her, my DON because this was a clinical issue, to let me know if this was a reportable incident to State. I asked during morning meeting too n Monday in front of other staff about whether it was reportable and she said no, it was part of his disease process. So I did not report. The ADM further said after the admission to the hospital, a hospital nurse called and talked to MDS RN F and the MDS RN F came to her and said the hospital was inferring that he had been burned. That was when the ADM said she went to the DON and she said she would call the hospital and tell them it was not a burn. The ADM said she did not discuss Resident #1's injury with anyone else, just the DON. She said she did not call corporate for counsel on whether to report it to HHSC as an injury of unknown origin and possible abuse/neglect. An interview with the CC-RN on 08/15/22 at 11:15 AM revealed he was an ER nurse in the past and had been a nurse for over [AGE] years. He said he trusted the DON's judgement and clinical assessment of Resident #1's hand injury and she did not feel it was a thermal burn. He said she knew what a burn was and he did as well and it did not present as such. CC-RN stated with a thermal burns, the blisters would not be identical in size on the top and palm of the hand and the fingers would be scalded, which they were not. He said in order to have been burned, someone would of had to take Resident #1's contracted hand, open it up, and submerge it into a hot liquid. He said that just was not possible and did not happen . He said the DON knew what a burn was and had she felt it was a burn, she would have reported it to ADM as an injury of unknown origin and proceeded with an investigation. But when she saw it, it was not presenting as a burn. The CC-RN said that he saw the color photos of Resident #1's left hand and he did not feel the resident had a thermal burn injury. He said the hospital was not open to communicating with him (specifically the initial MD evaluator of the burn) and he had spent hours trying to contact them to discuss the injury. The CC-RN said the hospital still continued to send residents to the facility for admission and the plan remained for Resident #1 to come back to the facility when he was discharged . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Reporting Incidents; State and Home Office revised 01/08/07 reflected, Reporting Guidelines to Home Office: .1. All fractures, serious head injuries, burns, lacerations requiring sutures, 2. All hospitalization s from an injury or unusual occurrence; .17. Complete an incident report of the resident's injury. Notify the physician and family member or legal guardian for all injury reports. Document all facts and environmental factors surrounding the variance. Document vital signs and assessment results as required. Document notification of all applicable parties in the clinical record and on Incident Report. Reporting Guidelines to the State of Texas: f there is a question about what to report or what not to report, contact Director of Risk management for clarification. All incidents must be reported to the DADS State Office, [NAME] Texas within 24 hours of learning of the incident; .Report: 1. Any facility or staff member who has cause to believe that the physical or mental health or welfare or a resident has been or may be adversely affected by the abuse or neglect .5. Abuse Allegation .6. Neglect Allegations .7. Serious Injury: Report all injuries that are determined to be serious by the examining physician or designee, nurse practitioner, or physician's assistant. Report the serious injury ONLY of it resulted from a facility practice, action/inaction by staff, or circumstances within the facility.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations are thoroughly investigated in response to allegations of abuse, neglect, exploitation or mistreatment, and precent further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress for one (Resident #1) of five residents reviewed for abuse, neglect, and exploitation. The facility staff failed to investigate an injury of unknown origin of Resident #1 when the resident was found to have a significant injury to his left hand, and whose source could not be identified by the facility. Resident #1 had to be sent to the ER the following day when he became unresponsive and the blisters had tripled in size, where he was diagnosed with second degree thermal burns to his whole left hand, sepsis and a urinary tract infection. The hospital notified the facility that there was a concern that the resident had been burned. The facility abuse/neglect coordinator did not initiate an provider investigation. This failure could place the residents at risk for further potential abuse due to uninvestigated allegations of abuse, neglect, and injuries of unknown origin. On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received the IJ template on 08/16/22 at 2:21 PM. Findings included: Review of facility's Abuse/Neglect policy revised 08/28/17, reflected, .The Abuse Preventionist will be responsible for receiving, leading the appropriate investigation, assure that required reporting is completed timely . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (A broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period. Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of skin breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting resident dressed this morning, aide notified nurse of skin issues. On top of resident's left hand was cluster of blisters, with the biggest one observed to have opened up on the top of his left hand. Other smaller blisters observed over left finger areas. Hand cleaned and covered with dry dressing and wound care notified. Called and left voicemail for RP. Review of Resident #1's nursing notes the next day on 07/25/22 at 7:31 AM written by LVN A reflected, While doing rounds at the end of shift, this nurse went to check on resident, dressing to left hand appeared slightly wet so nurse unwrapped it to assess before re-wrapping it. When dressing was taken off, this nurse noted existing rosy, red area to top of hand where the first blister had burst open the morning before. No drainage however noted to this area. To surrounding area was however noted multiple huge new clear fluid filled blisters around existing area, on all left fingers and knuckles, and two large blisters on the left palm of his hand. When nurse asked resident if he was in pain, he said no .MD notified immediately and order given to transfer to ER for further eval and to rule out any possible infections/contagious issues .While gathering resident's paperwork while resident was seated at the nurses' station, resident noted to become verbally unresponsive despite being given the sternal rub and was being shaken many times. Review of the facility's incident and accident logs for July 2022 revealed Resident #1 was not listed. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75. An interview with the hospital critical care RN on -7/28/22 at 12:37 PM revealed Resident #1 was presently at the hospital and had been diagnosed with second degree burns to his left hand, sepsis and a UTI. The RN said when she first saw Resident #1's left hand, she was re-wrapping it to do wound care. He had blistering and a large open to the back of his left hand and blistering to the front and back down to where the wrist started. His skin on the left hand was blistered with a giant open area to the back of the hand that was red and granulated, blistering to all four digits and thumb on the outside and palm side of the hand. She said there were no more skin issues beyond the left hand. The RN said Resident #1 was unable to tell her what happened and he had dementia and previous stokes and baseline of confusion with mumbling of inappropriate words. The critical care RN said the hospital was concerned because Resident #1 was contracted and immobile. She said she called the facility and spoke initially with MDS RN F who only read her a nursing progress note and did not have any further information. Then the DON called her 30 minutes later and did not believe it was a burn. The critical care RN said, I did tell the DON I thought it was a burn and if he had any new oils or lotions, hot water exposure and she told me this was first noticed in the middle of the night on the 24th by an aide, so that is the note that was read to me .This is pretty significant. She said when she told the DON about the burn, the DON replied that she had asked Resident #1 if he was in pain and he said no. The critical care RN said, My thing is he won't even tell you his name. He has dementia. He is not going to do this to himself. The critical care RN said, He came in septic, this poor man, I feel bad .it made me so mad. The critical care RN said she felt Resident #1 had an injury of unknown origin and it was suspicious because it was not an injury that he could do to himself. Review of Resident #1's hospital records revealed he arrived at the hospital emergency department on 07/25/22 at 8:06 AM and was tachycardic (a heart rate over 100 beats a minute) to 170's, blisters and loss of epithelial skin (the tissue which covers the internal and external surfaces of the body) on the dorsum (the corresponding area on the top part of the hand) of the left hand consistent with possible burns and his upper extremities were contracted. The ED's attending note stated, Patient was sent from a nursing home for elevated heart rate, was reported that yesterday he sustained some blisters on his hand from an unknown process. The ED medical doctor's final impression/diagnosis was, Atrial fibrillation with RVR (when the rapid contractions of the atria make the ventricles beat too quickly), urinary tract infection with hematuria (the presence of blood in a person's urine), site unspecified, pneumonia of right lung to infectious organism, unspecified part of lung, and burn. A request was made for wound care to assess his left hand due to it appearing to be a burn but unable to ascertain a source. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he presented to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat source to the body, causing an increase in the temperature of local tissue) with blisters on his left hand and fingers. He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1) 2 Palmar (palm of the hand) blisters superior to the palmar crease; blisters of [NAME] 5th digit (finger) over phalanges (the group of small bones that comprise the bony core of the digits (fingers) of the hand), blister on 4th digit fingertip and over middle phalanx (a bone of the finger); 2) 2nd degree burns of the dorsal (top) wrist and hand with absent epidermis (skin) several bullae (large blisters on the skin that are filled with clear fluid) including tubular bulla of dorsal 1st webspace, hemorrhagic blister (when blood pools and forms a blister) in 1st webspace, several small bullae over proximal (situated near) 4th and 5th digit, bulla of 4th digit middle phalanx. He was noted to be neurological confused and unable follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal bacitracin ointment, adaptic/xeroform, ABD pad and loose Kerlix wrap and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. Review of TULIP database on 07/27/22 revealed no evidence of a provider investigation report or a provider investigation for Resident #1's injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on 07/27/22 at 3:00 PM revealed Resident #1 was sent to the hospital because his hand needed to be looked at by a higher level. She said MDS RN F had talked to the critical care hospital RN the day before (07/26/22) who had implied that Resident #1 had been burned or abused. The DON then called the hospital RN because of her feeling the resident was abused and told her it was a skin issue, not abuse. The DON said she took a picture of Resident #1's left hand on Monday morning when he was sent out. She said his left hand was red with a cluster of blisters that had erupted. She said, Initially we had thought maybe this was cellulitis. She then said, When I saw it like this (showed her phone of Resident #1's left hand), I told [MD E] it was not presenting as cellulitis. She said MD E did not visit Resident #1 in person after being notified on Day 2 of the blisters and she did not send him the picture that she took of Resident #1's hand. The DON said when she saw how much bigger the blisters had gotten on the second day, was when Resident #1 was sent out for further evaluation. The DON said she felt it was some kind of infection, I think. The DON said she did not know how Resident #1 was doing while at the hospital. She said he was not interviewable and sometimes made grunts or would moan when he was in pain, but he did not talk at all. The DON said Resident #1 was not ambulatory, was almost max dependence on ADLs and he was bed bound and wheelchair bound. She said he never went out on pass and rarely had family visitors. The DON said a burn would definitely be red and raw, it could have some black areas around it, and around the edges it would be white with moisture associated skin damage from the resident's own fluid leaking out from the edge of the wound and it would be extremely painful and in various stages all the way to 3rd degree. She said what happened with Resident #1, happened very acutely, very fast. The DON said an incident report was not done because it was never anything to warrant an incident, it was not a wound or injury. She said a wound care nurse or doctor did not look at it and the blisters all happened within 24 hours. The DON said, I know it is not a burn because those blisters did not present like it was a burn. I have seen fluid filled blisters like that, that were not related to burn. That looked like a fluid infection going on in his body. She said the blisters were fluid filled and were small and rapidly grew over the course of that day. She said Resident #1 could not tell them anything about what happened but he could respond to painful stimuli and he never presented with any pain or tearfulness or guardedness. An interview with MDS RN F on 07/27/22 at 3:15 PM revealed the hospital critical care RN had called to find out what happened to Resident #1's hand and said his whole hand was burned. MDS RN F did not know details about it, so she read the progress notes to the hospital critical care RN and then told the DON about the call because the hospital RN sounded disbelieving. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LVN B on 07/28/22 at 10:51 AM revealed she did not see Resident #1 over the weekend of 07/23/22 and 07/24/22 but did see him when she arrived at work on Monday 07/25/22. LVN B said his skin was clear when she left work on Friday 07/22/22 but when she came back on 07/25/22, he had one big blister on the top of his left hand that had already busted and the night nurse (LVN A) was not sure what it was and no one could understand how he got blisters like that. LVN B said she did not know if it was a burn because something real hot would have had to caused it. She said Resident #1's index finger was really swollen and he had a blister on the pointer finger side going towards the thumb. LVN B said Resident #1 normally could talk, but he was not there at all, she shook him, called his name and tried to open his eyes to get a reaction, but he was not responding, which was unusual. She said he could not tell her if he was in pain. She said by that time, the overnight nurse (LVN A) had notified the DON and physician to see what they wanted to do and MD F said to send him out since no one knew what had happened. LVN B said after that, she googled burn blisters on the hand and the pictures on the internet looked like Resident #1's. LVN B said, But I don't want to say it is a burn, because that is not good. LVN B said she did not know if Resident #1 had an injury of unknown origin. She said that would be when a person could not tell how an injury occurred She then said, We don't know how this one occurred. A follow up interview with MDS RN F on 07/28/22 at 11:17 AM revealed she had been employed at the facility for a month and she was the RN manager on duty on Sunday 07/24/22 and had come to the facility last in the morning around 11 AM. She said she had not been notified of any issues related to Resident #1 but as the MOD, she went to each nurses' station, asked how things were going, if there were any new incidents and accidents and she was told no. She then went to the MDS office and did assessments and later helped serve dinner. She said she did not see Resident #1's hand. MDS RN F said she was first made aware of Resident #1's hand during the morning management meeting on Monday 07/25/22, after he had already been sent out. MDS RN F said an injury of unknown origin was something that was abnormal, that was not there before. If that occurs, the facility should look into what happened and start an investigation, see if it was suspicious. (continued on next page)

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	676052	A. Building B. Wing	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the overnight nurse, LVN A, on 07/28/22 at 11:56 AM revealed she had worked at the facility Saturday 2pm-10pm and the overnight shift (07/23/22) and on Sunday (07/24/22) she worked the overnight shift 10 PM-6 AM. LVN A said she was notified by a CNA in the early morning hours before the overnight shift was over Sunday morning (07/25/22) that the CNA was getting him up and noticed issues with his skin and she wanted LVN A to look at it. When LVN A went to his room, Resident #1 initially had a big blister right on top of his hand that had popped and little one right next to it that had not popped but one was draining. She said the skin was still on so she did not want to aggressively rub it and she covered it with a dry dressing and put it on the 24 hour report to remind herself. LVN A said they left him in bed at that time. LVN A said she did not contact MD E or an on-call doctor on Sunday 07/24/22 when she first noticed Resident #1's left hand injuries because the facility lets the treatment nurse look at it first. LVN A said she just cleaned it and wanted the wound nurse to look at it when she came in. She said the wound nurse did not normally work the weekends and that was why she made a note in the 24 hour report to remind herself and alert the oncoming nurse to follow up. However, she said Resident #1 was sent out to the ER the next day in the early morning before the wound care nurse could look at his hand. When LVN A came back to work later that day for her overnight shift (Sunday into Monday 07/24/22-07/25/22), she was rounding and when she looked at the dressing, it looked like it had dried so she changed it. When she unwrapped it, there were triple the amount of new blisters around the entire hand, like big, huge blisters which were not there the day before so the blisters tripled in numbers in 24 hours, and they were on the palm of his hand. LVN A said she cleaned it, wrapped his hand with a dry dressing and texted the DON asking her what to do. She said, As far as I know, there was nothing that had burned him, but the wound was growing. At that point, she called MD E and told him about it for the first time. He said initially he would refer to a dermatologist, but then said to send Resident #1 to the ER in case he had something contagious since it came on that rapidly. LVN A said, I don't know if he was reacting to anything or if he was burned. LVN A said she did not initially think it was a burn because no one had mentioned anything to her, But with the tripling of them (the blisters) the next day, with the wound wrapped up, I don't know. LVN A said an injury of unknown origin was when a person did not know how it occurred. Observation and record review of the 24-hour book for Hall 100 (Resident #1's hall) revealed no entries on 07/23/22 or 07/24/22 related to the resident. An interview with the wound care LVN G on 07/28/22 at 07/28/22 at 3:10 PM revealed that Resident #1 had not been on her caseload and she did not work over the weekend on 07/23/22-07/24/22. She said no one mentioned anything to her about Resident #1's hand and he had already been sent to the hospital by the time she arrived at work Monday 07/25/22. She said she only found out about it through hearing people talking about it conversationally in the facility. Wound Care LVN G said a burn could present differently, depending on the degree of it. She said there could be blistering, discoloration, redness, some swelling due to the degree, and some skin may be missing due to the degree of the burn. She said most second degree burns were blistered and a burn could re-blister, pop on their own and come back up. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA C on 07/28/22 at 12:25 PM revealed she had last seen Resident #1 on Friday 07/22/22 and his skin looked great, she could see his hands when she laid him down. When she saw him Monday morning 07/25/22, she was told that he maybe had an infection because his hand was wrapped. CNA C said then the overnight nurse, LVN A took off the dressing and she saw he had pink raw skin on top of his hand. She said she was wondering how that could have happened because Resident #1 always kept his hands balled up and only moved them to itch his face. CNA C described Resident #1's left hand as looking like person who got burned, because she had never seen an infection that took the skin off like that and that he had blisters everywhere on his fingers and palm. Resident #1 could not tell her what happened because he was blind and only spoke a few words and he was not responsive, which was not normal. CNA C said, I said y'all sure it not a burn and they were like shhhhh (be quiet sound) .at the same time I was like what if this is your family member? She said when Resident #1 was not responding to her, she tried to do a sternal rub, But nothing, like he was losing it. CNA C said she told the DON that she should take staff members off the schedule who had worked with Resident #1 before that time frame just in case, and investigate, and she just looked at me. She said, If it was my family member, I would want to know the facility is looking into it. An interview with CNA D on 07/28/22 at 3:58 PM revealed she had worked the overnight shift for the first time on Resident #1's hall on Saturday-Sunday shift (07/23/22-07/24/22), but she knew him from working with him on another hall. She said on that overnight shift, around 3:50 AM, she went in to check on him and he was quiet and she was worried he was not breathing but then looked closer and saw his chest was rising. She said he was a typically a heavy soil and outputs a lot and the entire night when she would go and check on him, he was dry up until 3:50 AM and that was unusual. CNA C said incontinence being not as frequent or not as much as it used to be could be a sign of the body shutting down. She said Resident #1 had not voided at all her shift until then. When she changed him, it was only urine and it could fill her palm so it was not much and he was laying on his hand so she turned him over. When CNA C turned him over, there was a thin brown layer of something next to him. She did not know what it was. She picked it up and then looked at this hand and saw the entire left layer of skin on his left hand was missing. She said, I was like oh my god, I lifted up his hand and he groaned when I lifted it up and it looked like he had been burned. CNA C then went to LVN A and asked what happened because it looked fresh because his fingers where white in color, like being in water too long but he was African American. She said Resident #1's hand was soggy and there were huge blisters all over his hand and fingers. CNA C said she had picked up the piece of his hand skin unknowingly, so she told LVN A. CNA C said Resident #1 was severely injured and he could not walk, see, or move his arms more than to his face, he was stuck in the fetal position and he could not have burned himself. She said LVN A wrapped his hand temporarily because there was puss on his hand. CNA C said Resident #1 did seem to be in pain, like the injury was hurting him. She said when she and LVN A pulled his hand up and started to wipe it down before it was wrapped, he was making little groans. CNA D said she felt like LVN A was not being responsive and CNA C was panicked because she had residents get hurt in front of her before and pass away, so Resident #1's hand made her emotional. She said, Someone that cannot move, cannot do this to themselves. I try not to freak out but there was no sense of urgency or care. When she (LVN A) wrapped his hand too, she didn't clean it, just put on a gauze pad and wrapped it real quick. I was like, just dry gauze on the open flesh, it will stick when you take it off. CNA D said LVN A did not talk to her the rest of the shift and CNA D later talked to the DON about her concerns and not wanting to work with that nurse again or on that hall. CNA D said the DON did make any inquiries into Resident #1's hand. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow up interview with the DON on 07/28/22 at 2:26 PM revealed she first saw Resident #1's hand on Sunday, 07/24/22 around 7AM because she had to swab him to test for COVID-19. LVN A had already seen his hand and the DON had been notified. When she went to his room, she saw the blisters on his left hand before they erupted. She said he had no indicators of pain and there was no other issues with his skin other than his left hand. The DON said she could not remember when she notified the ADM about Resident #1's hand. The DON said an injury of unknown origin was one that could not be described as to where it came from. She said she did not feel Resident #1 had an injury of unknown origin, she felt it was an infection, not an injury. She claimed no one from the hospital indicated to her that it was a burn. The DON said a nurse was not supposed to diagnose a resident, they can describe the situation to the physician. She said she did not talk to MD E on Sunday 07/24/22 so she did not describe Resident #1's skin change/injury to him, I assumed he had already been called. The DON said the injury did not qualify to be called to HHSC as a self-reported incident by the Abuse and Neglect Coordinator because it presented as an infection and Resident #1 had the ability to let them know if he was in pain, and he was not, and a burn would be extremely painful. The DON said if she had been notified from the hospital that the resident had second degree burns, then she would have notified the ADM and it would be reported to HHSC and an investigation would be started. An interview with MD E on 07/28/22 at 3:32 PM revealed he was the medical director for the facility and attending physician to Resident #1. He said he vaguely remembered being contacted by the facility Monday morning on 07/25/22 and they were asking him about the lesions he had which was a bug deal with Monkey Pox going on. He said the facility had no cases of Monkey Pox but it was number one on his list to watch out for and he did not want it to get loose in the facility so he wanted Resident #1 sent out. He said no one from the facility mentioned it could have been a burn and no one contacted him when the injury was first identified on Sunday 07/24/22 for a change in condition. MD E said, If a resident has big blisters all over his hand, they should have notified me for sure. I would have needed a description of the lesions. He said, A lot of times, I am not sure if the nurses are sure of what they are looking at or seeing. MD E said he remembered being sent a photo of Resident #1's hand on 07/25/22 and that was the reason he sent him out, when he saw it. MD E said she would consider something an injury of unknown origin is the facility did not have any indications of what caused the injury and could not identify any infections or inflammatory issues. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the ADM on 07/28/22 at 2:48 PM revealed she was the facility abuse and neglect coordinator and she investigated allegations to determine if there was abuse or not. In the same role, she reported any suspicious injuries and initiated investigations and resolved them one way or another. In that process, the ADM said she may suspend staff or implement things as a result of the allegation. The ADM said she was first told about Resident #1's injury when the DON said she was sending him out Monday morning on 07/25/22. She told the ADON it had something to do with a disease, or whatever disease state he was in, but the ADM could not state what that disease was and she did not ask. The ADM said no one notified her about the injury on Sunday 07/24/22 when the blistering was initially seen. If it was a burn, the ADM said the DON should have let her know, If it was an injury of unknown origin, absolutely. At the stand-up meeting on Monday 07/25/22, the DON stat So Monday, the DON said Resident #1 had been sent out already and that he had some blisters and they were not out of the norm of expectations from his diagnosis of whatever that is. The ADM said she had just seen the picture taken by LVN A of Resident #1's left hand. The ADM said, I have never seen that before in my life. They tried to show it to me before but I have a weak stomach. I will say I just need your clinical expertise. So when I saw the picture, when I saw the blisters, I was like what is that? She said the DON told her she had seen it before and there were some diseases that when there is a flare up and the body has nowhere to release those toxins, they could come out like that. The ADM stated, So I relied on her, my DON because this was a clinical issue, to let me know if this was a reportable incident to State. I asked during morning meeting too in on Monday in front of other staff about whether it was reportable and she said no, it was part of his disease process. So I did not report. The ADM further said after the admission to the hospital, a hospital nurse called and talked to MDS RN F and the MDS RN F came to her and said the hospital was inferring that he had been burned. That was when the ADM said she went to the DON and she said she would call the hospital and tell them it was not a burn. The ADM said she did not discuss Resident #1's injury with anyone else, just the DON. She said she did not call corporate for counsel on whether to report it to HHSC as an injury of unknown origin and possible abuse/neglect. An interview with the CC-RN on 08/15/22 at 11:15 AM revealed he was an ER nurse in the past and had been a nurse for over [AGE] years. He said he trusted the DON's judgement and clinical assessment of Resident #1's hand injury and she did not feel it was a thermal burn. He said she knew what a burn was and he did as well and it did not present as such. CC-RN stated with a thermal burns, the blisters would not be identical in size on the top and palm of the hand and the fingers would be scalded, which they were not. He said in order to have been burned, someone would of had to take Resident #1's contracted hand, open it up, and submerge it into a hot liquid. He said that just was not possible and did not happen. He said the DON knew what a burn was and had she felt it was a burn, she would have reported it to ADM as an injury of unknown origin and proceeded with an investigation. But when she saw it, it was not presenting as a burn. The CC-RN said that he saw the color photos of Resident #1's left hand and he did not feel the resident had a thermal burn injury. He said the hospital was not open to communicating with him (specifically the initial MD evaluator of the burn) and he had spent hours trying to contact them to discuss the injury. The CC-RN said the hospital still continued to send residents to the facility for admission and the plan remained for Resident #1 to come back to the facility when he was discharged . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Investigating Incidents of Unknown Origin revised January 2020, reflected, The facility will investigate incidents of unknown origin .1. The DON/designee will follow up on the incident report (Gather witness statements, interviewed, follow up on notification of family and physician, ensure completion of documentation, complete the quality assurance review, ensure the incident has been care-planned if required). 2. The incident will be tracked on SOC. 3. The DON/designee will initiated monitoring as indicated. 4. The DON/designee should follow up on the documentation daily until the investigation is complete. 5. Once investigation is completed, the documentation should be reviewed by the QAPI team. On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan for one (Resident #1) of five residents reviewed for quality of care. The facility failed to ensure Resident #1 was accurately assessed, monitored, and treated for an change of condition in his skin when the resident was found to have a significant injury of unknown source to his left hand. He was given a treatment for wound care without the physician being notified or providing orders. Resident #1 had to be sent to the ER the following day when he became unresponsive and the blisters had tripled in size, where he was diagnosed with second degree burns to his whole left hand, sepsis and a urinary tract infection. This failure placed residents at risk for skin alteration and injuries and could result in pain, decreased quality of life, serious illness and hospitalization . On 08/16/22 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/17/22, the facility remained out of compliance at a severity level of actual harm with potential for more than minimal harm that is not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received the IJ template on 08/16/22 at 2:21 PM. Findings included: Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (A broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of skin breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #1's most recent weekly skin assessment completed by LVN A on 07/21/22 reflected his skin color was normal with no bruising, skin tears, abrasions, lacerations, surgical incisions, rash, moisture associated skin damage or wounds. Review of Resident #1's most recent skin site identification from and shower sheet dated 07/22/22 reflected he was provided a shower; hair was washed and nails were cleaned with no indication of skin alteration. Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting resident dressed this morning, aide notified nurse of skin issues. On top of resident's left hand was cluster of blisters, with the biggest one observed to have opened up on the top of his left hand. Other smaller blisters observed over left finger areas. Hand cleaned and covered with dry dressing and wound care notified. Called and left voicemail for RP. Review of Resident #1's July 2022 physician's orders did not reflect an order for treatment to his left hand. Review of Resident #1's nursing notes the next day on 07/25/22 at 7:31 AM written by LVN A reflected, While doing rounds at the end of shift, this nurse went to check on resident, dressing to left hand appeared slightly wet so nurse unwrapped it to assess before re-wrapping it. When dressing was taken off, this nurse noted existing rosy, red area to top of hand where the first blister had burst open the morning before. No drainage however noted to this area. To surrounding area was however noted multiple huge new clear fluid filled blisters around existing area, on all left fingers and knuckles, and two large blisters on the left palm of his hand. When nurse asked resident if he was in pain, he said no .MD notified immediately and order given to transfer to ER for further eval and to rule out any possible infections/contagious issues .While gathering resident's paperwork while resident was seated at the nurses' station, resident noted to become verbally unresponsive despite being given the sternal rub and was being shaken many times. Review of the facility's incident and accident logs for July 2022 revealed Resident #1 was not listed. Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the hospital critical care RN on -7/28/22 at 12:37 PM revealed Resident #1 was presently at the hospital and had been diagnosed with second degree burns to his left hand, sepsis and a UTI. The RN said when she first saw Resident #1's left hand, she was re-wrapping it to do wound care. He had blistering and a large open to the back of his left hand and blistering to the front and back down to where the wrist started. His skin on the left hand was blistered with a giant open area to the back of the hand that was red and granulated, blistering to all four digits and thumb on the outside and palm side of the hand. She said there were no more skin issues beyond the left hand. The RN said Resident #1 was unable to tell her what happened and he had dementia and previous stokes and baseline of confusion with mumbling of inappropriate words. The critical care RN said the hospital was concerned because Resident #1 was contracted and immobile. She said she called the facility and spoke initially with MDS RN F who only read her a nursing progress note and did not have any further information. Then the DON called her 30 minutes later and did not believe it was a burn. The critical care RN said, Anyone can tell it is a burn. They did a dry dressing which was not appropriate, it should have been a wet dressing. She said if a dry dressing was applied to a burn such as Resident #1's, essentially it would stick to the wound and worsen it when it was removed. The critical care RN said she asked the DON why they chose that dressing and the DON responded they had notified the wound care nurse. The critical care RN said, I did tell the DON I thought it was a burn and if he had any new oils or lotions, hot water exposure and she told me this was first noticed in the middle of the night on the 24th by an aide, so that is the note that was read to me .This is pretty significant. She said when she told the DON about the burn, the DON replied that she had asked Resident #1 if he was in pain and he said no. The critical care RN said, My thing is he won't even tell you his name. He has dementia. He is not going to do this to himself. The critical care RN said, He came in septic, this poor man, I feel bad .it made me so mad. The critical care RN said she felt Resident #1 had an injury of unknown origin and it was suspicious because it was not an injury that he could do to himself. Review of Resident #1's hospital records revealed he arrived at the hospital emergency department on 07/25/22 at 8:06 AM and was tachycardic (a heart rate over 100 beats a minute) to 170's, blisters and loss of epithelial skin (the tissue which covers the internal and external surfaces of the body) on the dorsum (the corresponding area on the top part of the hand) of the left hand consistent with possible burns and his upper extremities were contracted. The ED's attending note stated, Patient was sent from a nursing home for elevated heart rate, was reported that yesterday he sustained some blisters on his hand from an unknown process. The ED medical doctor's final impression/diagnosis was, Atrial fibrillation with RVR (when the rapid contractions of the atria make the ventricles beat too quickly), urinary tract infection with hematuria (the presence of blood in a person's urine), site unspecified, pneumonia of right lung to infectious organism, unspecified part of lung, and burn. A request was made for wound care to assess his left hand due to it appearing to be a burn but unable to ascertain a source. (continued on next page)

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	676052	A. Building B. Wing	08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he presented to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat source to the body, causing an increase in the temperature of local tissue) with blisters on his left hand and fingers. He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1) 2 Palmar (palm of the hand) blisters superior to the palmar crease; blisters of [NAME] 5th digit (finger) over phalanges (the group of small bones that comprise the bony core of the digits (fingers) of the hand), blister on 4th digit fingertip and over middle phalanx (a bone of the finger); 2) 2nd degree burns of the dorsal (top) wrist and hand with absent epidermis (skin) several bullae (large blisters on the skin that are filled with clear fluid) including tubular bulla of dorsal 1st webspace, hemorrhagic blister (when blood pools and forms a blister) in 1st webspace, several small bullae over proximal (situated near) 4th and 5th digit, bulla of 4th digit middle phalanx. He was noted to be neurological confused and unable follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal bacitracin ointment, adaptic/xeroform, ABD pad and loose Kerlix wrap and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. An interview with the DON on 07/27/22 at 3:00 PM revealed Resident #1 was sent to the hospital because his hand needed to be looked at by a higher level. She said MDS RN F had talked to the critical care hospital RN the day before (07/26/22) who had implied that Resident #1 had been burned or abused. The DON then called the hospital RN because of her feeling the resident was abused and told her it was a skin issue, not abuse. The DON said she took a picture of Resident #1's left hand on Monday morning when he was sent out. She said his left hand was red with a cluster of blisters that had erupted. She said, Initially we had thought maybe this was cellulitis. She then said, When I saw it like this (showed her phone of Resident #1's left hand), I told [MD E] it was not presenting as cellulitis. She said MD E did not visit Resident #1 in person after being notified on Day 2 of the blisters and she did not send him the picture that she took of Resident #1's hand. She did not have a reason as to why she did not send him the photo at that time. The DON said when she saw how much bigger the blisters had gotten on the second day, was when Resident #1 was sent out for further evaluation. The DON said she felt it was some kind of infection, I think. the DON said she did not know how Resident #1 was doing while at the hospital. She said he was not interviewable and sometimes made grunts or would moan when he was in pain, but he did not talk at all. The DON said Resident #1 was not ambulatory, was almost max dependence on ADLs and he was bed bound and wheelchair bound. She said he never went out on pass and rarely had family visitors. The DON said a burn would definitely be red and raw, it could have some black areas around it, and around the edges it would be white with moisture associated skin damage from the resident's own fluid leaking out from the edge of the wound and it would be extremely painful and in various stages all the way to 3rd degree. She said what happened with Resident #1, happened very acutely, very fast. The DON said an incident report was not done because it was never anything to warrant an incident, it was not a wound or injury. She said a wound care nurse or doctor did not look at it and the blisters all happened within 24 hours. The DON said, I know it is not a burn because those blisters did not present like it was a burn. I have seen fluid filled blisters like that, that were not related to burn. That looked like a fluid infection going on in his body. She said the blisters were fluid filled and were small and rapidly grew over the course of that day. She said Resident #1 could not tell them anything about what happened but he could respond to painful stimuli and he never presented with any pain or tearfulness or guardedness. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with MDS RN F on 07/27/22 at 3:15 PM revealed the hospital critical care RN had called to find out what happened to Resident #1's hand and said his whole hand was burned. MDS RN F did not know details about it, so she read the progress notes to the hospital critical care RN and then told the DON about the call because the hospital RN sounded disbelieving. An interview with LVN B on 07/28/22 at 10:51 AM revealed she did not see Resident #1 over the weekend of 07/23/22 and 07/24/22 but did see him when she arrived at work on Monday 07/25/22. LVN B said his skin was clear when she left work on Friday 07/22/22 but when she came back on 07/25/22, he had one big blister on the top of his left hand that had already busted and the night nurse (LVN A) was not sure what it was and no one could understand how he got blisters like that. LVN B said she did not know if it was a burn because something real hot would have had to caused it. She said Resident #1's index finger was really swollen and he had a blister on the pointer finger side going towards the thumb. LVN B said Resident #1 normally could talk, but he was not there at all, she shook him, called his name and tried to open his eyes to get a reaction, but he was not responding, which was unusual. She said he could not tell her if he was in pain. She said by that time, the overnight nurse (LVN A) had notified the DON and physician to see what they wanted to do and MD E said to send him out since no one knew what had happened. LVN B said after that, she googled burn blisters on the hand and the pictures on the internet looked like Resident #1's. LVN B said, But I don't want to say it is a burn, because that is not good. A follow up interview with MDS RN F on 07/28/22 at 11:17 AM revealed she had been employed at the facility for a month and she was the RN manager on duty on Sunday 07/24/22 and had come to the facility last in the morning around 11 AM. She said she had not been notified of any issues related to Resident #1 but as the MOD, she went to each nurses' station, asked how things were going, ask if there were any new incidents and accidents and she was told no. She then went to the MDS office and did assessments and later helped serve dinner. She said she did not see Resident #1's hand. MDS RN F said she was first made aware of Resident #1's hand during the morning management meeting on Monday 07/25/22, after he had already been sent out. She said, A nurse cannot diagnose and did not diagnose, that is why the doctor was called. That was [MD E]. MDS RN F said she did not know if MD E diagnosed Resident #1 but he ordered the treatment. She did not know what kind of treatment MD E ordered and said she was not the front line nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the overnight nurse, LVN A, on 07/28/22 at 11:56 AM revealed she had worked at the facility Saturday 2pm-10pm and the overnight shift (07/23/22) and on Sunday (07/24/22) she worked the overnight shift 10 PM-6 AM. LVN A said she was notified by a CNA D in the early morning hours before the overnight shift was over Sunday morning (07/25/22) that the CNA was getting him up and noticed issues with his skin and she wanted LVN A to look at it. When LVN A went to his room, Resident #1 initially had a big blister right on top of his hand that had popped and little one right next to it that had not popped but one was draining. She said the skin was still on so she did not want to aggressively rub it and she covered it with a dry dressing and put it on the 24 hour report to remind herself. LVN A said they left him in bed at that time. LVN A said she did not contact MD E or an on-call doctor on Sunday 07/24/22 when she first noticed Resident #1's left hand injuries because the facility lets the treatment nurse look at it first. LVN A said she just cleaned it and wanted the wound nurse to look at it when she came in. She said the wound nurse did not normally work the weekends and that was why she made a note in the 24-hour report to remind herself and alert the oncoming nurse to follow up. However, she said Resident #1 was sent out to the ER the next day in the early morning before the wound care nurse could look at his hand. When LVN A came back to work later that day for her overnight shift (Sunday into Monday 07/24/22-07/25/22), she was rounding and when she looked at the dressing, it looked like it had dried so she changed it. When she unwrapped it, there were triple the amount of new blisters around the entire hand, like big, huge blisters which were not there the day before so the blisters tripled in numbers in 24 hours, and they were on the palm of his hand. LVN A said she cleaned it, wrapped his hand with a dry dressing and texted the DON asking her what to do. She said, As far as I know, there was nothing that had burned him, but the wound was growing. At that point, she called MD E and told him about it for the first time. He said initially he would refer to a dermatologist, but then said to send Resident #1 to the ER in case he had something contagious since it came on that rapidly. LVN A said, I don't know if he was reacting to anything or if he was burned. LVN A said she did not initially think it was a burn because no one had mentioned anything to her, But with the tripling of them (the blisters) the next day, with the wound wrapped up, I don't know. Observation and record review of the 24-hour book for Hall 100 (Resident #1's hall) revealed no entries on 07/23/22 or 07/24/22 related to the resident. An interview with the wound care LVN G on 07/28/22 at 07/28/22 at 3:10 PM revealed that Resident #1 had not been on her caseload and she did not work over the weekend on 07/23/22-07/24/22. She said no one mentioned anything to her about Resident #1's hand and he had already been sent to the hospital by the time she arrived at work Monday 07/25/22. She said she only found out about it through hearing people talking about it conversationally in the facility. Wound Care LVN G said a burn could present differently, depending on the degree of it. She said there could be blistering, discoloration, redness, some swelling due to the degree, and some skin may be missing due to the degree of the burn. She said most second degree burns were blistered and a burn could re-blister, pop on their own and come back up. Wound care LVN G said she would typically treat a burn by notifying the doctor and getting an order. She stated, There is a lot of stuff as nurses you don't see, even if you have been a nurse for years. My first notion is to call the doctor, take a picture and show them. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA C on 07/28/22 at 12:25 PM revealed she had last seen Resident #1 on Friday 07/22/22 and his skin looked great, she could see his hands when she laid him down. When she saw him Monday morning 07/25/22, she was told that he maybe had an infection because his hand was wrapped. CNA C said then the overnight nurse, LVN A took off the dressing and she saw he had pink raw skin on top of his hand. She said she was wondering how that could have happened because Resident #1 always kept his hands balled up and only moved them to itch his face. CNA C described Resident #1's left hand as looking like person who got burned, because she had never seen an infection that took the skin off like that and that he had blisters everywhere on his fingers and palm. Resident #1 could not tell her what happened because he was blind and only spoke a few words and he was not responsive, which was not normal. CNA C said, I said y'all sure it not a burn and they were like shhhhh (be quiet sound) .at the same time I was like what if this is your family member? CNA C said she was asking various nurses and management about it, but did not give names. She said when Resident #1 was not responding to her, she tried to do a sternal rub, But nothing, like he was losing it. CNA C said she told the DON that she should take staff members off the schedule who had worked with Resident #1 before that time frame just in case, and investigate, and she just looked at me. She said, If it was my family member, I would want to know the facility is looking into it. An interview with the DON on 07/28/22 at 2:26 PM revealed the facility did not contact the wound care physician to have he/she assess Resident #1's left hand injury because the resident had already been sent out to the hospital. She also stated there was no wound care nurse working on the weekend. The DON said she believed MD E was notified about Resident #1 on Sunday 07/24/22 prior to her arriving at the facility by LVN A. The DON said she was at the facility that day, arriving early in the morning around 6am because she needed to swab residents for COVID-19 due to a recent positive case. She said thought LVN A notified MD E. However, the DON said she did not verify that LVN A called him and did not follow up with her afterwards to see what his orders were. She said she had just assumed LVN A called MD E and she had no idea why she did not call him. The DON said she first saw Resident #1' hand when she arrived that morning around 7AM because she had to swab him to test for COVID19. LVN A had already seen his hand and the DON had been notified. When she went to his room, she saw the blisters on his left hand before they erupted. She said he had no indicators of pain and there was no other issues with his skin other than his left hand. The DON said she did not tell LVN A to contact the doctor (MD E) and had assumed she had already done that. The DON said that she was the RN in the facility that morning and the manager on duty was MDS RN F who arrived later that day and took over. She said MDS RN F did not see Resident #1's left hand. The DON said she had since started an in-service with the nursing staff on 07/28/22 about how to identify a change in condition. She said when a change in condition occurred with a resident, she expected the nurses to identify the change, complete an SBAR and make sure the resident is stable, call the physician and family and if there was an order given, to follow it up with any further changes. The DON said she initiated that in-service training because there was no order for Resident's treatment given to his left hand. The DON said she saw that LVN A treated it, but there was not an order for it. She had not yet in-serviced LVN A. However, the DON also admitted that she was the one who told LVN A what type of dressing to use, based on facility standing orders for basic issues like blisters and skin tears and that she did not want to put a cream or ointment on it, just a non-adhesive dressing wrapped in Kurlex. The DON said, If it was a burn, I would have sent him out to the hospital. With burns, we typically don't treat initial burns on the skin. We would wash under cold water and apply Silverdine maybe, but it's whatever the doctor would choose. A copy of the facility standing orders for basic skin treatment was requested but never provided. The DON said a nurse was not supposed to diagnose a resident, they can describe the situation to the physician. She said she did not talk to MD E on Sunday 07/24/22 so she did not describe Resident #1's skin change/injury to him, I assumed he had already been called. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA D on 07/28/22 at 3:58 PM revealed she had worked the overnight shift for the first time on Resident #1's hall on Saturday-Sunday shift (07/23/22-07/24/22), but she knew him from working with him on another hall. She said on that overnight shift, around 3:50 AM, she went in to check on him and he was quiet and she was worried he was not breathing but then looked closer and saw his chest was rising. She said he was a typically a heavy soil and outputs a lot and the entire night when she would go and check on him, he was dry up until 3:50 AM and that was unusual. CNA C said incontinence being not as frequent or not as much as it used to could be a sign of the body shutting down. She said Resident #1 had not voided at all her shift until then. When she changed him, it was only urine and it could fill her palm so it was not much and he was laying on his hand so she turned him over. When CNA C turned him over, there was a thin brown layer of something next to him. She did not know what it was. She picked it up and then looked at this hand and saw the entire left layer of skin on his left hand was missing. She said, I was like oh my god, I lifted up his hand and he groaned when I lifted it up and it looked like he had been burned. CNA C then went to LVN A and asked what happened because it looked fresh because his fingers where white in color, like being in water too long but he was African American. She said Resident #1's hand was soggy and there were huge blisters all over his hand and fingers. CNA C said she had picked up the piece of his hand skin unknowingly, so she told LVN A. CNA C said Resident #1 was severely injured and he could not walk, see, or move his arms more than to his face, he was stuck in the fetal position and he could not have burned himself. She said LVN A wrapped his hand temporarily because there was puss on his hand. CNA C said Resident #1 did seem to be in pain, like the injury was hurting him. She said when she and LVN A pulled his hand up and started to wipe it down before it was wrapped, he was making little groans. CNA D said she felt like LVN A was not being responsive and CNA C was panicked because she had residents get hurt in front of her before and pass away, so Resident #1's hand made her emotional. She said, Someone that cannot move, cannot do this to themselves. I try not to freak out but there was no sense of urgency or care. When she (LVN A) wrapped his hand too, she didn't clean it, just put on a gauze pad and wrapped it real quick. I was like, just dry gauze on the open flesh, it will stick when you take it off. CNA D said LVN A did not talk to her the rest of the shift and CNA D later talked to the DON about her concerns and not wanting to work with that nurse again or on that hall. CNA D said the DON did not make any inquiries into Resident #1's hand. An interview with MD E on 07/28/22 at 3:32 PM revealed he was the medical director for the facility and attending physician to Resident #1. He said he vaguely remembered being contacted by the facility Monday morning on 07/25/22 and they were asking him about the lesions he had which was a big deal with Monkey Pox going on. He said the facility had no cases of Monkey Pox but it was number one on his list to watch out for and he did not want it to get loose in the facility, so he wanted Resident #1 sent out. He said no one from the facility mentioned it could have been a burn and no one contacted him when the injury was first identified on Sunday 07/24/22 for a change in condition. MD E said, If a resident has big blisters all over his hand, they should have notified me for sure. I would have needed a description of the lesions. He said, A lot of times, I am not sure if the nurses are sure of what they are looking at or seeing. MD E said he remembered being sent a photo of Resident #1's hand on 07/25/22 and that was the reason he sent him out, when he saw it. MD E said he would consider something an injury of unknown origin is the facility did not have any indications of what caused the injury and could not identify any infections or inflammatory issues. He said it if Resident #1 had burns on his hand and any skin was inflamed underneath it, he would want to use petroleum, skin prep and iodine dressing, but if the skin was broken, he would do another type of dressing, it just depended on the extent of the injury. (continued on next page)

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